State of Hawaii
Department of Health

Child and Adolescent
Mental Health Division

Annual Performance Report
Fiscal Year 2002

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For the Period of July 1, 2001 to June 30, 2002
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Introduction

The Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health conducts an in-depth evaluation of its performance and functioning on an annual basis in addition to quarterly analyses. The purpose of this report is to provide a public summary and critical review of the information gathered during the annual evaluation process. CAMHD gathers a wide variety of information about the performance of its operations. This information may be summarized into five major categories. First, population information is collected to understand the characteristics of the children, youth, and families that are served. Second, service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Third, financial information is gathered about the cost of services. Fourth, system information is collected about the quality and operations of the statewide infrastructure needed to support children, youth, and families. Finally, outcome information is examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth, and families. This report summarizes the information available in these five categories for Fiscal Year 2001 - 2002 (July 1, 2001 through June 30, 2002).

Method

Data for this report were gathered from a wide variety of sources. The primary source of information is the Child and Adolescent Mental Health Management Information System (CAMHMIS), which supports registration of child and youth with CAMHD, authorization of services, electronic billing for services, and outcome monitoring functions. To include information on additional expenditures that are not electronically billed through CAMHMIS, financial information is reported from the Financial Accounting and Management Information System (FAMIS). System information was collected from independent databases maintained by numerous offices and committees within CAMHD. Although these are too numerous to list in summary here, detailed information on methodology is available in Appendix B.

Results

Population Characteristics

CAMHD provided case management services for 4,227 children, youth, and families over the past year. During the year, 370 youth were newly registered with CAMHD and 242 were re-admissions of youth who had been previously discharged from CAMHD. A total of 2,327 youth were discharged during the year. The large number of discharges was due in part to the reorganization and transfer of services for youth with Pervasive Developmental Disorders (e.g., Autism-spectrum disorders) to the Developmental Disabilities Division and the Department of Education. The final child registration count as of June 30, 2002 was 2,496 youth.

Approximately three-quarters of registered youth were male (72%) and the average age was 13.4 years with a range from 3 to 21 years. A wide range of ethnicity was represented (see Table 1) with Mixed (27.5%), Caucasian (21.8%), Hawaiian (21.2%), Filipino (7.7%), and Japanese (6.2%) accounting for 85% of youth with ethnic information available. Notable minorities of registered youth were also involved with the Department of Human Services (8.8%), had a Family Court hearing (14.6%), or were eligible for Quest (20.7%). A small percentage (3.6%) of registered youth were incarcerated at the Hawaii Youth Correctional Facility or Detention Home. Because the interagency involvement information is gathered based

Table 1. Ethnic Distribution of Registered Youth.

Ethnicity	N	% of Available
African-American	61	2.2%
African, Other	7	0.3%
American Indian	8	0.3%
Asian, Other	40	1.5%
Caucasian, Other	599	21.8%
Chamorro	1	0.04%
Chinese	51	1.9%
Filipino	211	7.7%
Hawaiian	582	21.2%
Hispanic, Other	31	1.1%
Japanese	170	6.2%
Korean	19	0.7%
Micronesian	11	0.4%
Mixed	753	27.5%
Pacific Islander, Other	35	1.3%
Portuguese	75	2.7%
Puerto Rican	19	0.7%
Samoan	69	2.5%
Not Available	1,485	35.1%

on care coordinator reports that are entered into CAMHMIS, failure to identify, report, or update electronic records would tend to cause underestimation of interagency involvement. Therefore, "true" rates of interagency involvement are likely somewhat higher than reported here.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 2). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top four diagnoses were attentional disorders (22.9%), disruptive behavior disorders (19.6%), pervasive developmental disorders (16.5%), and mood disorders (15.7%). As the year ended, children and youth with pervasive developmental disorders were transferring to the Developmental Disabilities Division, so the remaining CAMHD population is expected to be primarily attentional, disruptive behavior, and mood disorders each accounting for 20 to 30% of registered youth.

Table 2. Diagnostic Distribution of Registered Youth.

Any Diagnosis of	N	%
Attentional	967	22.9%
Disruptive Behavior	830	19.6%
Pervasive Developmental	696	16.5%
Mood	665	15.7%
Adjustment	389	9.2%
Miscellaneous	346	8.2%
Anxiety	343	8.1%
None Recorded	206	4.9%
Mental Retardation	147	3.5%
Substance-Related	99	2.3%
Deferred	31	0.7%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

In addition to providing case management services for all registered youth, when appropriate, direct services are procured for youth from the CAMHD provider network. Services were procured for 2,753 children, youth, and families in fiscal year 2002, which represented about two-thirds (65%) of registered youth receiving case management services. During the year, CAMHD procured services for 212 newly registered youth and 160 re-admitted youth who had been previously discharged. A total of 1,242 youth who had services procured during the year were also discharged during the year. Again, the large number of discharges was due in part to the transfer of services for youth with Pervasive Developmental Disorders (e.g., Autism-spectrum disorders) to the Developmental Disabilities Division. The final procured services count as of June 30, 2002 was 1,700 youth, so that 68% of registered youth receiving case management services also had services procured through CAMHMIS at year-end. Youth without services procured during fiscal year 2002 were accounted for by three primary factors. Three quarters (74%) were discharged during the year, 16% were admissions with services being arranged, and 39% received less intensive services through the Mokihana project, which are not directly procured through CAMHD.

Table 3. Ethnic Distribution of Youth with Procured Services.

Ethnicity	N	% of Available
African-American	54	2.6%
African, Other	6	0.3%
American Indian	6	0.3%
Asian, Other	29	1.4%
Caucasian, Other	486	23.3%
Chamorro	1	0.0%
Chinese	45	2.2%
Filipino	138	6.6%
Hawaiian	409	19.6%
Hispanic, Other	22	1.1%
Japanese	136	6.5%
Korean	14	0.7%
Micronesian	7	0.3%
Mixed	585	28.0%
Pacific Islander, Other	30	1.4%
Portuguese	57	2.7%
Puerto Rican	16	0.8%
Samoan	45	2.2%
Not Available	667	24.2%

Approximately three-quarters of youth with services procured were male (72%) and the average age was 13.0 years with a range from 3 to 21 years. A wide range of ethnicity was represented (see Table 3) with Mixed (28.0%), Caucasian (23.3%), Hawaiian (19.6%), Filipino (6.6%), and Japanese (6.5%) accounting for 84% of youth with ethnic information available. The similarity of the gender and ethnicity distributions for registered youth and youth receiving procured services reveals a lack of systemic bias favoring the purchase of services for some gender or ethnic groups over others. However, there is some variability across ethnic groups. For example, 88% of African-American and Chinese youth who were registered had services procured, whereas

approximately 65% of Filipino, Micronesian, and Samoan youth who were registered had services procured. The most notable difference is that ethnic information is available for a larger percentage of youth receiving services than for all registered youth receiving case management (i.e., 45% of those with unavailable ethnic information have services procured).

This difference may be due to several reasons. For example, care coordinators may form stronger relationships with children, youth, and families that have services procured, which makes gathering and disclosure of ethnic information more likely. Alternatively, families that do not wish to disclose ethnic information may not be as effective in advocating to receive services for their youth or may have participated less and dropped out of services offered during prior years. It is also feasible that some ethnic groups are less likely to disclose their ethnicity. In this case, the lack of ethnic information may obscure a systematic bias in service procurement patterns. The currently available information does not help discriminate among these possibilities.

When interagency involvement is examined, relative to all registered youth, a somewhat larger proportion of youth with interagency involvement had services procured. Specifically, 9.8% of youth with services procured were also involved with the Department of Human Services, 17.9% had a Family Court hearing, 4.9% were incarcerated at the Hawaii Youth Correctional Facility or Detention Home (14.6%), and 22.6% were eligible for Quest.

Consistent with the diagnostic distribution for registered youth, the top four diagnostic categories for youth with services procured were pervasive developmental disorders (23.1%), attentional disorders (21.8%), disruptive behavior disorders (19.9%), and mood disorders (15.7%). The most notable differences in these distributions were that a disproportionately large percentage of youth with pervasive developmental disorders have services procured and a disproportionately smaller percentage of youth with adjustment disorders or no diagnoses have services procured.

Table 3. Diagnostic Distribution of Youth with Procured Services.

Any Diagnosis of	N	%
Pervasive Developmental	635	23.1%
Attentional	599	21.8%
Disruptive Behavior	549	19.9%
Mood	431	15.7%
Miscellaneous	257	9.3%
Anxiety	222	8.1%
Adjustment	211	7.7%
Mental Retardation	95	3.5%
Substance-Related	67	2.4%
None Recorded	45	1.6%
Deferred	24	0.9%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Service Utilization

CAMHD tracks service utilization through two primary mechanisms. First, services that are electronically procured through CAMHMIS are recorded directly by the system. Second, the Clinical Services Office maintains a database of daily census information for strategically identified services that complements the CAMHMIS system. For services that are not electronically procured, information from the clinical services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a quarterly service management report that contains more detailed information than the summary presented here.

Fiscal year 2002 was a time of considerable evolution of services for CAMHD. The beginning of the year was characterized by completion of the large-scale transition of low-end, less intensive services to the School-Based Behavioral Health (SBBH) program of the Department of Education. As previously noted, the end of the year was characterized by the transition of pervasive developmental disorder services to the Developmental Disabilities Division and the Department of Education. In conjunction with these transitions, CAMHD revised its service array and opened competition for a new set of six-year contracts for its provider network. In addition to the removal of its low-end services, CAMHD also terminated its support for Partial Hospitalization and Day Treatment programs. Further, CAMHD added support for Respite Home and Intensive Day Stabilization services.

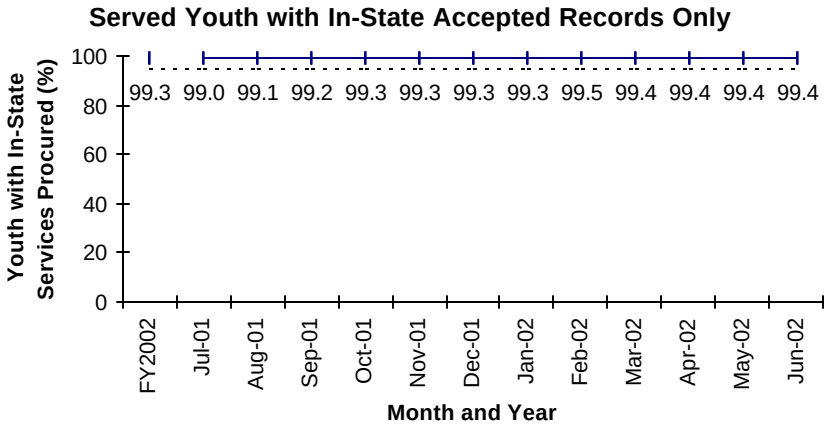
Services may be generally divided into the three major classes of out-of-state, out-of-home services, and in-home services. A core principle of CAMHD is to provide services within the least restrictive, yet therapeutic environment. To monitor its performance in this regard, CAMHD expects that at least 98% of its youth receive services within the State of Hawaii and that at least 75% of its youth receive services in their home. These performance targets were

exceeded for every month of fiscal year 2002, with an average of 99.3% of youth only receiving services within the state and 79% of youth only receiving services in their home environment.

For finer-grained analysis of its performance with respect to providing services in the least restrictive environment, CAMHD generally expects that within the out-of-home and in-home service arrays, the higher levels of care will be used less frequently than the lower levels of care. Table 4 presents the average number of youth receiving each level of care in the service array, along with the total number of youth receiving each service during the year.

The vast majority of in-home services were provided in the form of Intensive In-home services and Multisystemic Therapy. Approximately 31 youth per month received Day Treatment services and another 10 youth per month received Partial Hospitalization. As previously noted, these latter levels of care were being discontinued so that the number served monthly was significantly reduced from a high of 12 to a year-end of 4 youth receiving Partial Hospitalization and from a high of 48 to a year-end of 23 youth receiving Day Treatment. With the transition of less intensive services to SBBH, CAMHD expected reductions in procurement of less intensive services. Indeed, the use of less intensive services decreased from a monthly high of 844 youth to a year-end of 689 youth. However, CAMHD continued to procure some form of less intensive services for approximately one-third of the registered population and one-half of the served population.

Out-of-home services also generally followed the expected trend of less use of more restrictive services. Less than one percent of the served population received any out-of-state services and 5% received hospital-based services.



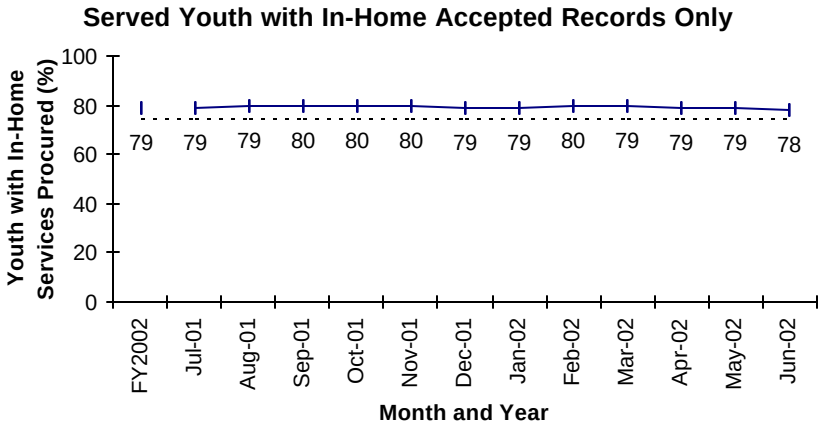


Table 4. Service Utilization Summary.

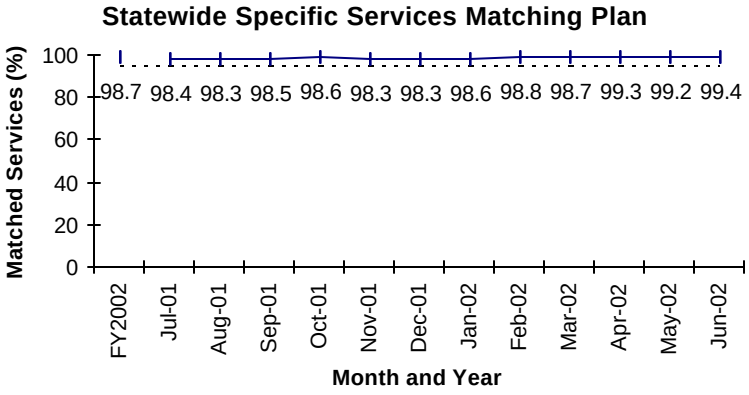
Any Receipt of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	12	22	0.5%	0.8%
Hospital Residential	38	131	3.1%	4.8%
Community High Risk	10	12	0.3%	0.4%
Community Residential	115	273	6.5%	9.9%
Therapeutic Group Home	81	190	4.5%	6.9%
Therapeutic Family Home	135	246	5.8%	8.9%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	10	37	0.9%	1.3%
Day Treatment	31	54	1.3%	2.0%
Multisystemic Therapy	117	345	8.2%	12.5%
Intensive In-Home	885	1,527	36.1%	55.5%
Flex	133	463	11.0%	16.8%
Respite	193	315	11.0%	16.8%
Less Intensive	786	1,331	31.5%	48.3%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

In contrast, approximately 10% received some form of community residential services and roughly 16% received services in a group or family home environment. The pattern breaks down a bit when individual levels of care are examined. Specifically, it is apparent that more youth receive Community-Based Residential (CBR) services than either Therapeutic Group Home (TGH) or Therapeutic Family Home (TFH) services. Further, throughout the year, the monthly averages were fairly stable for each of these groups (±6% for CBR; ±8% for TGH, and ±4% for TFH) and did not show consistent increasing or decreasing trends.

Further analysis is needed to determine why Community-Based Residential services are used at a higher rate than Therapeutic Group Homes or Therapeutic Family Homes. Tentative hypotheses are (a) that Community-Based Residential Services include intensive on-site educational/instructional support whereas the therapeutic home environments do not, (b) the availability and geographic distribution of group and family home placements are limited, (c) when treatment teams select out-of-home placements, then tend to prefer the most comprehensive and intensive services available, or (d) the actual distribution of youths' needs does not follow the pattern predicted by the least restrictive environment ideal.

To monitor its performance related to the timely and appropriate access to needed services, CAMHD tracks service gaps and mismatches on a monthly basis. A service gap is defined as the failure to provide any service within 30 days of identifying a youth's need for service. A service mismatch is defined as a failure to provide the specific service requested by a team within 30 days of the request. CAMHD expects to serve at least 98% of its youth without a service gap and 95% of its youth without a service mismatch. In fiscal year 2002, only a single youth experienced a service gap and an average of 98.7% of registered youth were provided with matched services. The relevant performance targets were exceeded during every month of the year.



Financial

CAMHD relies on several sources of information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). For a variety of reasons (e.g., cost reimbursement contracts, emergency services), unit cost information may not be available in CAMHMIS. Where possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and family guidance centers. Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through FAMIS. For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and family guidance centers.

FAMIS indicated that total general fund expenditures for fiscal year 2002 were $100,280,680. This is equivalent to $23,724 per registered youth and $36,426 per youth with services procured. General fund expenditures for *procured services only* totaled $83,673,891, which equates to $18,795 per registered youth and $30,394 per youth with services procured. Family guidance center expenditures were $10,888,839 ($2,576 per registered youth and $3,955 per youth with services procured) and central office expenditures were 5,717,949 ($1,353 per registered youth and $2,077 per youth with services procured). Combined expenditures for *procured services and case management services* totaled $94,562,731. Thus, 94.3% of total fiscal year 2002 general fund expenditures and encumbrances were spent on providing case management or procuring direct services to children, youth, and families.

Table 5. Total and per youth average cost of services for each level of care in order of decreasing restrictiveness.

Any Receipt of Services	Total Cost ($)	% of Total ($)	Cost per Youth ($)
Out-of-State	1,184,485	1.5%	93,278
Hospital Residential	6,391,250	8.2%	86,656
Community High Risk	1,787,940	2.3%	158,695
Community Residential	13,967,832	17.8%	64,195
Therapeutic Group Home	8,150,817	10.4%	66,195
Therapeutic Family Home	7,694,324	9.8%	53,752
Respite Home	-	-	-
Intensive Day Stabilization	-	-	-
Partial Hospitalization	405,750	0.5%	61,070
Day Treatment	1,438,947	1.8%	71,363
Multisystemic Therapy	2,340,730	3.0%	23,952
Intensive In-Home	13,220,068	16.9%	26,288
Flex	601,526	0.8%	53,235
Respite	621,881	0.8%	36,080
Less Intensive	20,495,405	26.2%	33,231

Note: Cost per youth represents the total cost for all services during the year allocated to level of care based on duplicated youth counts. Thus, the average per youth for a level of care includes total expenditures for youth who received that level of care at some point during the year. If youth received multiple services, then total expenditures for that youth are represented at multiple levels of care.

Of the $83,673,891 in total general fund expenditures and encumbrances for procured services reported by FAMIS, CAMHMIS tracked $78,300,954 (93.6%). Detailed allocation of this cost information by level of care is presented in Table 5. In-home and less intensive services accounted for 50% ($39,124,037), out-of-home services accounted for 48.5% ($37,992,163), and out-of-state services accounted for 1.5% ($1,184,485) of expenditures.

Overall, the largest total expenditures were for less intensive, intensive in-home, and community-based residential services, which collectively accounted for 61% of total expenditures for procured services tracked by CAMHMIS. Within the in-home service array, youth receiving day treatment had the highest average total cost for the year, followed by youth receiving partial hospitalization. The average annual cost per youth was significantly lower for intensive home and community services. On average, youth receiving multisystemic therapy services incurred somewhat fewer costs than other intensive in-home services.

Within the out-of-home service array, the three least restrictive levels of care were also the three categories with the largest total expenditures. Specifically, community-based residential services was the single largest category of expenditures, followed by therapeutic group homes and therapeutic family homes. The most expensive levels of care on a per youth basis were community high-risk residential, out-of-state-services, and hospital-based residential, respectively.

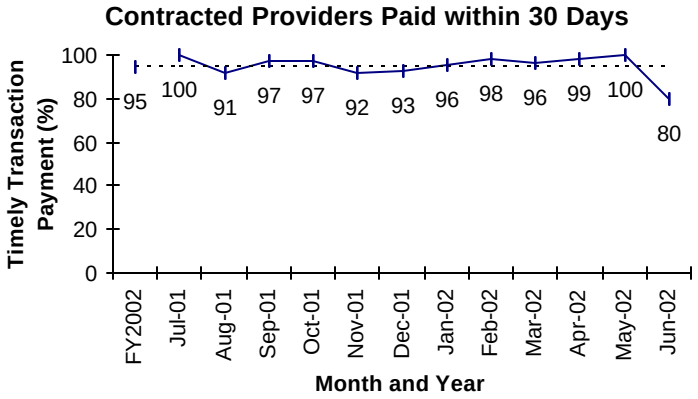
Community high-risk services are the secure services provided to juvenile sex offenders at the Waimano facility. Although CAMHMIS estimates utilization based on service authorizations for community high-risk services, this estimate is close to the $1,756,244 recorded by the CAMHD fiscal office as expended for this service exclusive of assessment services. The fact that the annual cost per youth for this level of care is by far the most expensive is due in part to the fact that there is relatively little turnover for this service. Once entered into this service, youth tended to remain throughout the year. Therefore, despite a monthly rate approximating that for hospital-based services, the actual cost per youth is considerably higher on an annual basis.

Further, it is interesting to note that the average annual cost per youth for therapeutic group home services exceeded that for community-based residential services, both of which were considerably more expensive (> $10,000) than the average annual cost per youth for therapeutic family homes. Despite lower monthly rates and annual costs for therapeutic group home services specifically, youth receiving these services had also received additional services that resulted in higher overall average annual costs than youth receiving community residential services. This may have resulted from (a) youth "stepping down" from higher levels of care, (b) youth "stepping up" to higher levels of care, or (c) from the receipt of large amounts of adjunctive services at lower care levels in addition to therapeutic group home services. Further analysis is necessary to discriminate among these possible explanations.

The performance target for general fund expenditures and encumbrances is to remain within budget on a quarterly basis. However, the specific performance measure is that CAMHD will seek fund reallocation or request a special appropriation if expenditures exceed budgeted amounts within any quarter. During fiscal year 2002, total general fund expenditures and encumbrances exceeded budgeted amounts in all four quarters and the excesses were covered

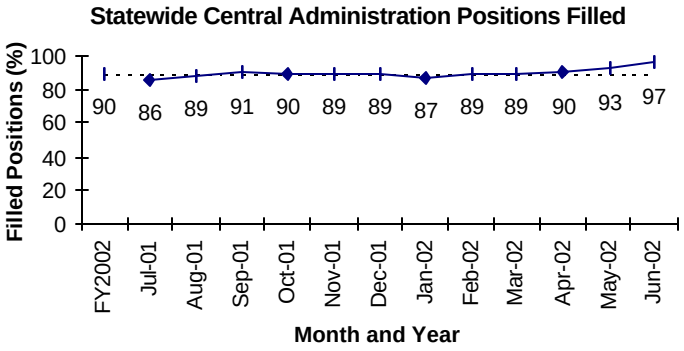
by departmental reallocation of funds. Within specific categories, central office expenditures were under budget for three of four quarters for an annual budget surplus of $189,000, service expenditures and encumbrances exceeded budgeted amounts in three of four quarters for an annual excess of $798,000, and family guidance center expenditures exceeded budget in all four quarters for an annual excess of $242,000.

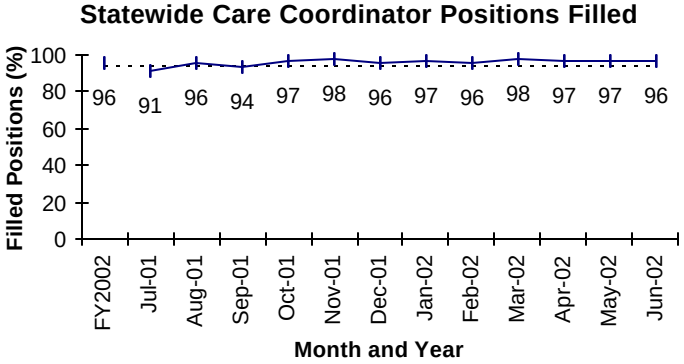
A second financially-related performance indicator involves timely payment to contracted providers for services rendered. The specific performance target is that 95% of contracted providers should be paid within 30 days of valid billing invoices. This goal was met with an average of 95% provider payments completed on time. On a monthly basis, this goal was achieved during eight months including a five-month success streak from January to May. However, the year ended with an outlier at a low of 80% timely payment for June of 2002. Although it is not clear exactly what contributed to this significantly reduced performance at year-end, during that time considerable energy was invested in finalizing new contracts and resolving disputes to prepare for fiscal year 2003, revising the CAMHMIS database to manage the new business rules, and managing personnel changes.



System Information

The infrastructure for the CAMHD system consists of four parts, the central administrative office, the family guidance centers, the standing committees, and the contracted provider network. The central office and family guidance centers have allocated positions occupied by state employees. The standing committees are chaired by CAMHD employees and include representatives from a broad array of stakeholder groups including central office, family guidance centers, network providers, families, universities, and other state agencies. To understand and manage the wide array of activities performed throughout CAMHD, performance measures and targets have been identified throughout the system. The infrastructure performance measurement system was being significantly developed and revised during fiscal year 2002. Many new performance measures were added and others were revised, so that comprehensive data were not available by year-end. Nevertheless, the available information is summarized in this report.

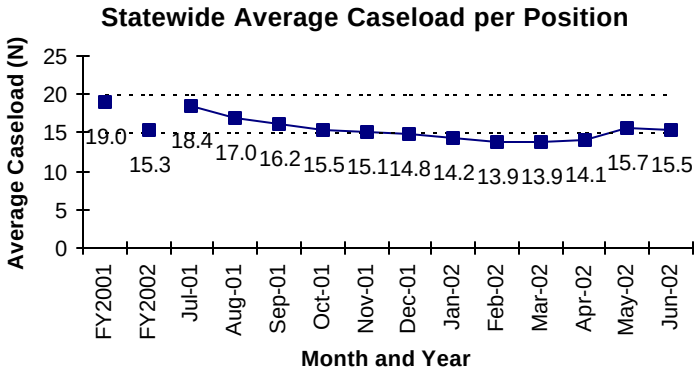




The people of CAMHD are key to the health and efficiency of its operations. Therefore, three core personnel measures were identified to monitor the availability and workload of key staff. Specifically, CAMHD expects to maintain 90% occupancy of administrative positions and 95% occupancy of the care coordination positions allocated to the division. Further, CAMHD seeks to maintain average caseloads of 15-20 for its care coordination personnel.

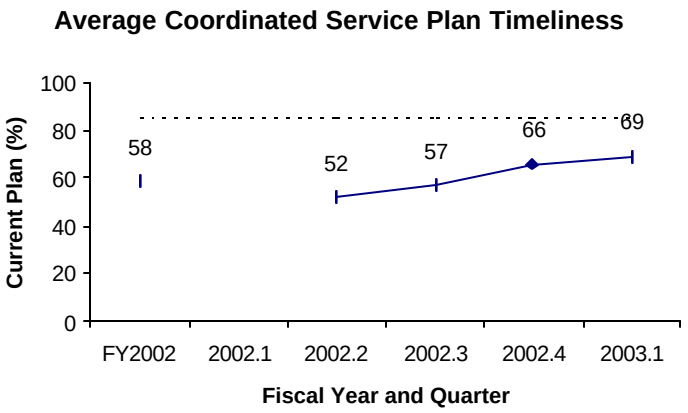
During fiscal year 2002, the performance goals were successfully achieved for all measures.

Care coordination position occupancy averaged 96%, central administration position occupancy averaged 90%, and average caseloads were 15.3 youth per care coordinator. Central administration position occupancy began the year at its low, increased to the target level by the end of the first quarter, and then remained slightly below the performance target for most of the year. During the final few months of the year, the occupancy rate improved rapidly and ended at the yearly high. Care coordination position occupancy also began the year at its low, increased to near the target range in the first quarter, and then exceeded the performance goal for the remainder of the year.

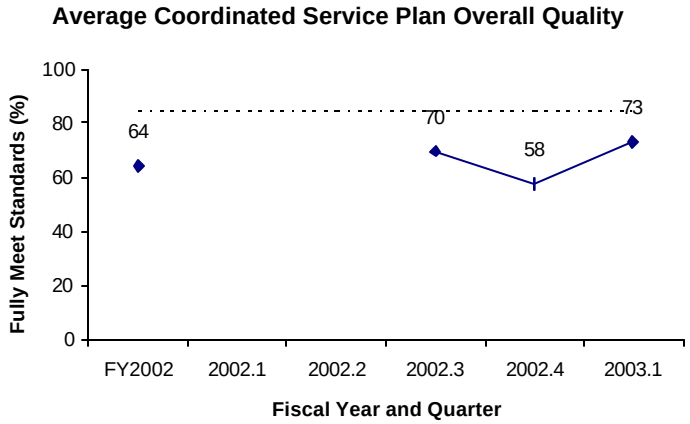


The average caseloads for care coordinators varied considerably over the course of the year as the on-going transitions of care proceed. Early in the year, caseloads were near the upper end of the target range, but steadily dropped below the lower target as cases were actively discharged. This trend was corrected in May and June through the reduction of workforce, so that the year ended with caseloads at the lower end of the targeted range.

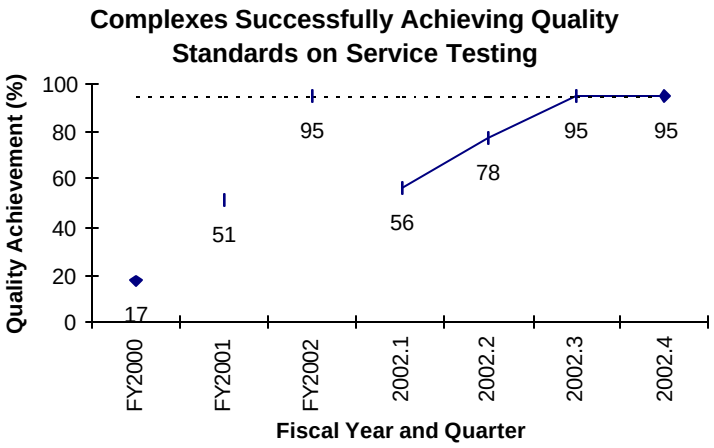
The Coordinated Service Plan (CSP) is a key document in organizing services for youth and communicating with families, treatment teams, and providers. As a performance goal, 85% of youth are expected to have current CSPs and quarterly CSP quality reviews are expected to find that 85% of reviewed indicators fully meet quality standards. The quality assurance process for CSPs was revised in 2002, so that timeliness data were only available second through fourth quarter and quality data were only available for the third and fourth quarters. Results indicated that on average, 58% of youth had a current CSP and 64% of CSP quality indicators fully met standards. While these results are below expectations, it is a positive indication that the percent of current CSPs increased from 52% to 66% during the year, although this increase in timeliness seems to have coincided with a decrease in quality from 70% to 58%. When youth are newly registered with the CAMHD system, the intake process allows 30 days for the initial CSPs to be completed. Therefore, the performance indicator for current CSPs will be less than 100% to the extent that new youth were recently registered in the system. Preliminary data from first quarter of fiscal year 2003 suggest that the timeliness trend has continued to improve and that CSP Quality has improved above the baseline level.



Another key component of the CAMHD quality-monitoring plan involves in-depths reviews of family guidance center and network provider performance. During 2002, primary external monitoring of family guidance centers continued to use the Service Testing protocols for school complexes that were not yet deemed to be in full compliance. Performance monitoring of network providers was conducted using similar procedures, although separate protocols and a different leveling system were used to score provider achievements. Performance goals

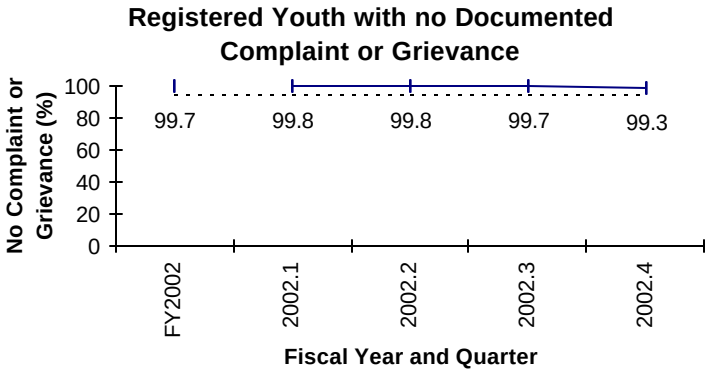


for these measures are the 95% of complexes maintain acceptable scoring on service testing (and, in future years, internal reviews), 100% of network providers are monitored annually, and 85% of provider agencies are rated as performing at acceptable levels. For fiscal year 2002, the performance targets were successfully achieved for service testing results (95%) and network provider monitoring (100%). The percent of providers rated as acceptable during their reviews (79%) was below the performance target.



Family guidance center performance is also evaluated based on the percent of the performance targets described in this report that family guidance centers meet or exceed on a quarterly basis. For fiscal year 2002, family guidance centers successfully met performance goals for 70% of performance measures on average. Although more than two-thirds of targets were met, this success rate falls short of the 85% target selected for this indicator. Family guidance centers demonstrated strengths in the areas of providing timely and appropriate services in the least restrictive environment with few complaints or grievances filed involving children, youth, and families. The family guidance centers primary struggled with performance targets that involved keeping expenditures on budget, completing timely and high quality CSPs, and completing timely, standardized outcome assessments that demonstrate child status improvements (see Child and Family Outcomes below).

Finally, CAMHD evaluates the quality of its system by examining the number of complaints and grievances that are filed by stakeholders. CAMHD expects that 95% of registered youth will not have any documented complaints or grievances, 85% of network provider agencies will not have any documented complaint or grievance, and 85% of network provider agencies will not file complaint or grievance regarding CAMHD. During fiscal year 2002, each of these performance goals was exceeded. Specifically, 99.7% of registered youth did not have a documented complaint or grievance, 91% of network providers did not have a documented complaint or grievance, and 87% of network provider agencies did not file a complaint or grievance about CAMHD. Further, these performance goals were met for each quarter, with the exception that in the third and fourth quarters more complaints or grievances regarding CAMHD performance were filed by network provider agencies (i.e., 61% and 80% of agencies respectively did not file complaints or grievances regarding CAMHD performance). These cases almost exclusively involve grievances about denial, delay, or inadequate payments from CAMHD.



Well-quantified performance measures of central offices operations and committee functioning were not available during fiscal year 2002. These measures are in the process of development and baseline data collection will begin as data becomes available. Therefore, although the performance of administrative sections and committees could not be analyzed for fiscal year 2002, such analysis should be feasible in fiscal year 2003.

Child and Family Outcomes

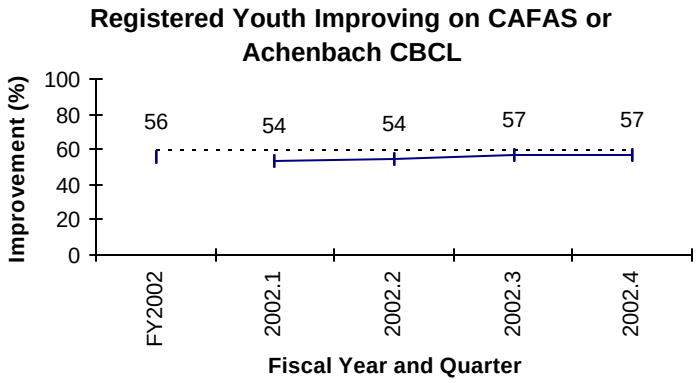
An overarching goal of CAMHD is to contribute to a happier and healthier Hawaii through improvements in the mental health and functioning of the children, youth, and families served by the system. To monitor performance toward this goal, CAMHD measures youth mental fitness using both ratings of child status during service testing

reviews and standardized, objective assessment instruments. Specifically, children's functioning is measured using the Child and Adolescent Functional Assessment Scale (CAFAS). Children's competence and behavioral health are measured using the Achenbach Child Behavior Checklist (CBCL).

The performance goal for assessment of child status during Service Testing is that 85% of children reviewed will be rated with acceptable performance. This goal was successfully achieved during fiscal year 2002. Of the 169 youth reviewed during service testing, 87% were rated as performing at an acceptable level.

Because standardized, objective assessments of child status are more expensive and difficult to obtain, CAMHD has set two types of performance goals for these measures. The first goal is that 85% of youth will have a CAFAS and CBCL completed. This target is designed to promote the availability of sufficient and high quality data to support decision-making regarding child and family outcomes. The second performance goal is that 60% of youth sampled show improvement on the CAFAS or CBCL since entering the CAMHD system. Although at first glance this second performance target might seem low, it is important to bear in mind that as of July 2001, CAMHD transferred less intensive services to SBBH, so that CAMHD is now serving youth with more severe challenges needing more intensive services.

Timely completion of outcome data was probably the area of weakest performance of all performance measures in fiscal year 2002. On average, CAFAS assessments were completed on 35% of registered youth and CBCL assessments were completed on 5% of registered youth. At least two scores on an instrument are necessary to examine improvement or decline in a child's status on that measure. As of year-end, sufficient data were available to examine changes for 1,935 youth. On average, 56% of youth with valid scores during 2002 demonstrated improvement in their functioning or behavioral health. Although the generality of these findings to the entire CAMHD population remains questionable due to the limited completion rates for CAFAS and CBCL assessments, the available data suggest that the majority of youth in the CAMHD system demonstrate an improving trend in their functioning and behavioral health. At year-end, the child improvement rate is approximately 3% below the performance target.



During fiscal year 2002, insufficient information was available on child and family satisfaction with services to warrant analysis. To remedy this situation, collection of family and youth satisfaction surveys was included in the proposal competition for outreach services for statewide family organizations. Thus, during fiscal year 2003, family and youth satisfaction information will be collected by the CAMHD family organization partner and made available for future analysis.

Summary and Conclusions

In sum, fiscal year 2002 demonstrated a number of strengths in CAMHD system performance. Most notably, Service Testing reviews met performance targets and supported the determination that the state achieved substantial compliance with the Felix Consent Decree. Consistent evidence indicated that CAMHD provided timely and appropriate services in the least restrictive environment with few documented complaints and grievances involving youth or network providers. Although the expenditures for some units of the divisions exceeded budgets, excesses were addressed through a departmental reallocation of funds. Nevertheless, spending within budget allocations will remain a preferred goal for the upcoming year. The areas demonstrating a need for improvement include the production of timely and high quality Coordinated Service Plans and completion of timely child status assessments. Maintaining and consolidating the trend toward improved CSPs will also remain a key goal for fiscal year 2003 as will the gathering of outcome data that could support stronger conclusions about the status of children, youth, and families served by CAMHD. Finally, CAMHD will pursue continued quality development of the provider network.